STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00164092. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00162280 completed on January 14,2015 Complaint IN00164092-Substantiated. Federal/State deficiency related to the allegations was cited at F323. Survey dates: February 9, 2015 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Survey team: Regina Sanders, RN,TC Census by bed type: SNF: 08 SNF/NF: 71 Total: 79 Census payor type: Medicare: 08 Medicaid: 63 Other: 8 Total: 79	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 6 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. -3.1. Quality review completed on February 15, 2015, by Janelyn Kulik, RN.			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to, ensure residents' were free of accident hazards, related to bed rails on the bed, failed to ensure a fall intervention was in place, related to a mattress with bolsters, and failed to report and assess a resident about an allegation of a fall for 4 of 4 residents reviewed for falls, in a total sample of 6. (#B, #C, #E, and #G). Findings include: 1. Resident #E's record was reviewed on	F000323	**F-Tag 323 Free of Accidents Hazards/Supervision/Devices:** It is the policy of Miller's Merry Manor, Hobart to ensure that each residentreceives and the facility provides the necessary care and services to attain ormaintain the highest practicable physical, mental and psychosocial well-being,in accordance with the comprehensive assessment and plan of care. Resident E and Resident G: Resident E was assessed and placed in thecenter of the bed following the occurrence. The side rail for Resident E wasfixed/tightened the following morning after the occurrence, no concerns	02/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	02/09/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, fractured right hip and diabetes. A Physician's order, dated 01/15/15, indicated one bed rail upon bed to assist with positioning. The Admission Minimum Data Assessment (MDS), dated 01/07/15, indicated the resident had moderately impaired cognition, required extensive assistance of two or more for transfers and bed mobility, and had one fall without injury. A care plan, dated 01/08/15, indicated the resident was at risk for falls, the interventions included, provide an assistive device to promote safety as, assist rail and low bed, replace one assist rail (written on 01/17/15). An, "Occurrence Initial Assessment", dated 01/17/15 at 10:20 (no a.m. or p.m. documented) indicated, "...Resident noted between bed rails (sic) with the ; (sic) upper body between rails lower out...no injury noted upon assessment at this time..." An Incident Investigation, dated 01/17/15 at 10:20 p.m., indicated the resident had attempted to get out of bed and the		noted.The side rail on the bed of Resident G was fixed/tightened immediately. Pleasenote that the space between the siderail and mattress measured 2 ½, which isless than the State allotted measurement of 4 ¾. Resident C: Thebolster mattress overlay was ordered and placed on the air mattress immediatelyonce arrival to the facility. Resident B: Theresident was out at the hospital during this time. *All residents are at risk to be affected by the deficientpractice.* An audit was completed on all beds withremovable side rails; any concerns noted were fixed immediately or railsremoved. All staff will be in-serviced onor before 2/20/15 tonot pull on or unscrew rails and to promptly notify the charge nurse upon discoveryof a loose siderail. Maintenance will then be notified and if needed theresident will be placed in an alternate bed until repaired. An audit wascompleted on all residents Fall Care plans to ensure accuracy of interventionsin place. It is the policy to complete a fall assessment upon admission andwith significant change in status to determine resident specific fall riskfactors. The plan of care is updated toreflect resident specific risk factors and interventions to reduce/preventfuture falls. Charge nurses are responsible to complete the initial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was repositioned to the center of the bed. During an interview on 02/09/15 at 2:30 p.m., LPN #1 indicated the resident's lower body was laying out of the bed. She indicated the resident was between the bed rails. She indicated the resident's arm and head was between the bed rail and the mattress and both of the resident's legs were on the floor. She indicated the bed rail was loose and the resident had no red marks on her skin. She indicated the bed rail was tightened up. LPN #1 demonstrated in an empty resident bed, how the resident was lying with arm/head between the mattress and bed rail. During an interview on 02/09/15 at 2:35 p.m., the Administrator indicated she was unaware the resident was caught between the bed rails. During an interview on 02/09/15 at 3:50 p.m., the Director of Maintenance indicated the Maintenance Department does a general bed check monthly on the beds, which included assessing the bed rails. The Director of Maintenance indicated the bed was in the resident's room was checked on 12/28/14. The Administrator indicated the resident had been admitted in the facility on 01/07/15, which was after the bed check had been		occurrence,assessment, and to initiate post fall investigation tool with onset of a fallor any alleged fall. The nurse managersreview the post fall investigation form for root cause analysis, properintervention, and prompt updates are made to plan of care for the residentinterventions put into place. Chargenurses document the initial fall occurrences on the 24 hour report tool whichis reviewed daily by the nurse managers. The CNA assignment sheets will beupdated and used as a communication device to staff for all new fall interventions. The nurse managers random walking roundsof the units and will make observations to ensure fall interventions are inplace as identified in plan of care. All residents alleging a fall will beinvestigated and assessed for fall interventions. All licensed staff werein-serviced according to the facility policy on assessments by 02/20/2015(Attachment A). All licensed and non-licensed staff were in-serviced by 02/20/2015on reporting resident concerns to the nurse in a timely manner. The maintenance director and/ordesignee will complete the QA tool titled "Bed System Review" (AttachmentC) audit on removeable siderails in the facility weekly for 4 weeks, biweeklyfor a month and monthly thereafter to monitor siderails. Siderails willbe checked for proper placement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed. The Director of Maintenance and Administrator indicated the bed in the resident's room was not necessarily the same bed which was checked by the Maintenance Department. They both indicated beds get changed around and bed rails get changed. They both indicated they were unaware the resident was caught between the mattress and the bed rail. The Director of Maintenance indicated he was unaware the resident was between the bed rails, he had not checked other beds with the same bed rails. 2. Resident #G's record was reviewed on 02/09/15 at 4:30 p.m. The resident's diagnoses included, but were not limited to, stroke and Alzheimer's disease. The Annual MDS assessment, dated 11/13/14, indicated the resident's cognition level was unable to be assessed, never/rarely made decisions, was dependent for bed mobility and transfers, has had no falls, and bed rails were not used. A care plan, dated 06/07/12, indicated the resident had a need for two, half rails up on the bed to provide support for a low air loss mattress. During an observation on 02/09/15 at		and fit to bed frame. Any identified issueswill be immediately corrected and documented on facility QA tracking log. QA tracking logs are reviewed during the monthly facility QA meeting to ensureongoing compliance. The corrective action will be monitored utilizing the QAtool “24 Hour Condition Report Review” (Attachment B). Tool will be completeddaily for 1 week, 3x weekly for (3) weeks, weekly for (4) weeks, then monthlyby the DON or other designee. Any concerns identified will be documentedon quality assurance tracking log and corrected upon discovery. All QAtools and any findings will be reviewed monthly in the facility QualityAssurance meeting to ensure ongoing compliance. Date of Compliance: 2/24/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3:15 p.m. with the Administrator and the Maintenance Director present, Resident #G's left bed rail was loose and leaned outward from the bed. A fist of a hand was able to fit between the mattress and the bed rail. There was approximately 4 inches between the mattress and the bed rail. The Administrator measured the area and indicated there was two and half inches between the bed rail and mattress. The Administrator indicated an arm and or a head could fit between the mattress and the bed rail. During an interview on 02/09/15 at 3:50 p.m., the Maintenance Director indicated Resident #G's bed was last checked on 01/27/15. 3. Resident #C's record was reviewed on 02/09/15 at 1:20 p.m. The resident's diagnoses included, but were not limited to, paraplegia, hypertension, and convulsions. The resident was a new admission into the facility and a MDS assessment had not been completed. A care plan, dated 01/26/15, indicated the resident was a risk for falls. The interventions included, bolster overlay to the mattress.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An, "Occurrence Initial Assessment", dated 01/26/15 at 11:20 (no a.m. or p.m. documented" indicated the resident was observed laying on the side of the bed on the floor with his head touching the breaks on the bed and no injuries were assessed. The incident investigation, dated 01/26/15 at 11:20 a.m., indicated the resident was observed laying on the side of bed on his back with his head rest on the brakes of the bed. The action taken to prevent reoccurrence, indicated a new mattress with bolsters was ordered. During an observation with the Administrator present, on 02/09/15 at 3:15 p.m., Resident #C's bed did not have bolsters. The Administrator indicated the resident did not have bolsters on the bed. During an interview on 02/09/15 at 3:50 p.m., the Director of Nursing indicated the resident had bolsters on his bed. She indicated the resident no longer had bolsters on the bed. During an interview on 02/09/15 at 4:30 p.m., she indicated the mattress company picked up the bolster overlay on 02/02/15 when the resident was in the hospital and when he returned to the facility, the bolsters were not re-ordered from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	company. 4. Resident #B's record was reviewed on 02/09/15 at 11 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with delusions and congestive heart failure. A Quarterly Minimum Data Set assessment, dated 11/20/14, indicated the resident's cognition was moderately impaired, had delusions, required extensive assistance of two or more for bed mobility and was total assistance of two or more for transfers. A care plan, dated 01/25/11, indicated the resident was a fall risk and required a mechanical lift with two assistance for all transfers, which was added on 06/19/12. A care plan, dated 02/02/11, indicated the resident had a potential for pain related to osteoarthritis. The interventions indicated, assess pain with scale of 1-10 and record on prn (as needed) pain flow sheet, medicate with prn (as needed) medications and assess pain before and after. The Physician's Recapitulation Orders, dated 01/15, indicated the following orders: 09/18/14-acetaminophen 325 mg (milligrams), two tablets every four hours			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	as needed for mild pain and 09/18/14-acetaminophen 325 mg, two tablets one time a day for osteoarthritis, shoulder pain at 6 a.m. The Medication Administration Record indicated the resident had not received the as needed acetaminophen for pain on 01/23/15. A Nurses' Progress Note, dated 1/20/15 at 1:23 p.m., indicated, "orders received for Robitussin (sic) (cough medication)...every 4 hours prn (as needed). dx (diagnosis) cough. resident (sic) daughter (name) mad aware." The next documented Nurses' Progress Note, dated 01/24/15 at 7:57 a.m., indicated the resident's Physician and Responsible party was notified. A Nurses' Progress Note, dated 01/24/15 at 7:58 a.m., indicated the resident complained of right elbow pain and stated she had fallen on 01/22/15. A Nurses' Progress Note, dated 01/24/15 at 2:52 p.m., indicated the Physician and the Responsible Party was notified of the fractured right elbow and the Physician gave an order to transfer the resident to the hospital.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	There was no documentation in the Progress Notes from 01/20/15 at 1:23 p.m. . through 01/24/15 at 7:57 a.m. A Radiology Report, dated 01/24/15, indicated the resident had fracture of the right elbow. A Transfer Form, dated 01/24/15, no time documented, indicated the resident was being transferred to the hospital due to a fractured right elbow. An, Occurrence Initial Assessment, dated 01/24/14 at 7 a.m., indicated, "...Writer was notified by another staff member that resident was experiencing pain to her right elbow. Upon question to resident by writer, resident stated there was an incident 2 days ago and she was in pain. Writer notified D.O.N. (Director of Nursing), family (name), doctor and (Company Name) for an x-ray...pain to right elbow...Indicate level of pain...Hurts a little more..." The facility investigation, dated 01/24/15, indicated CNA #2 (worked the evening of 01/22/15 and 01/23/15) was interviewed. CNA #2 indicated the resident had told the CNA on 01/23/15 she had fallen and her arm hurt. The resident indicated someone had dropped her on the floor. CNA #2 indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident did not go to dinner and the resident would not let her take the mechanical lift sling out from underneath her and CNA #2 received help from CNA #3 to take the sling out from behind the resident. The investigation did not indicate CNA #2 had reported the resident said she fell and the complaints of pain to the Nurse on duty. The investigation indicated CNA #3 (worked midnights 01/23/15) was interviewed. CNA #3 indicated the resident had told her and CNA #2 her arm was hurting. The investigation did not indicate CNA #3 had reported the pain to the Nurse on duty. There was a lack of documentation to indicate the Nurse on duty on the evening shift had been interviewed. There was a lack of documentation to indicate the resident's pain had been assessed and treated. During an interview on 02/09/15 at 3:30 p.m., the Administrator indicated she had not interviewed the Nurse on duty (LPN #4). The Administrator indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA's should have reported the pain and the complaints of the fall to the Nurse. During an interview on 02/09/15 at 3:45 p.m., LPN #4 indicated the CNA #3 and CNA #4 had not reported the resident made the statement she fell and someone had, "dropped her". LPN #4 indicated the CNA's had not reported to her the resident had complained of pain. LPN #4 indicated when she gave the resident her medications before supper, the resident said she could not hold her own medications in her hands because it hurts. LPN #4 indicated the resident often complains of discomfort so she thought this was the resident's usual behavior. LPN #4 indicated she had not assessed the resident's arm pain. CNA #2 and CNA #3 were unable to be reached to be interviewed on 02/09/15. This Federal Tag relates to Complaint IN00164092. 3.1-45(a)(1) 3.1-45(a)(2)			